



MESA CHOICE HEALTH PLAN
2010 CORE Benefits Package
For
Full-time Employees

The information in this workbook provides general information on programs and summaries of health benefits offered to City of Mesa members.

All information is subject to change and is not a guarantee of benefits.

For detailed information pertaining to the City's benefit offerings, please review the City of Mesa's Plan Document available online at:

www.mesachip.org

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ACTION CHECKLIST

Use this checklist as you read the Benefits Package information to help you complete the enrollment process.

COVERAGE OPTIONS – Indicate what level of coverage applies to you.

- ☐ Member Only (Single Coverage)
- ☐ Member and Family (Family Coverage)
- ☐ Opt Out – Choose this option if you have other health insurance coverage, and you do not want to be covered by specific City of Mesa plan.

CURRENT DEPENDENTS – Make a list of your family members who are to be covered under your plan. You will need dates of birth, social security numbers, and other verification documents if you are covering dependents on your plan. See page 4 for documents required.

Dependent Name	Date of Birth	Social Security Number	Attending School?

NEW DEPENDENTS/CHANGE IN FAMILY STATUS: If you have or anticipate a Family Status Change (i.e., newborn, marriage, divorce, or adoption) that becomes effective after your benefit effective date please contact the Employee Benefits Office **immediately** at (480) 644-3329.

MEDICAL PLAN OPTIONS – See pages 10-11 for coverage info and page 7 for premiums.

- ☐ Choice PPO – 80/20 Plan
- ☐ Basic Choice PPO – 50/50 Plan
- ☐ Choice Plus PPO – 90/10 Plan
- ☐ Copay Choice - \$20 copay for most services

DENTAL PLAN OPTIONS – See pages 17-18 for premiums and coverage information.

- ☐ Preventative Choice – 80/20 Plan, \$500 annual maximum payable. Orthodontia, periodontal and endodontal services **not** included.
- ☐ Dental Choice – 80/20 Plan, \$1200 annual maximum payable. **Orthodontia is not included on this plan.**
- ☐ Dental Choice Plus – 80/20 Plan, \$1500 annual maximum payable. Orthodontia **is** included for children under age 19. (Adult orthodontia is not covered on any of the dental plans)

VISION PLAN OPTIONS – See pages 19-20 for [coverage information](#) and page 19 for [premiums](#).

- ☐ Basic Vision - 12/24/24
- ☐ Vision Plus - 12/12/12

FLEXIBLE SPENDING OPTIONS – Refer to page 21 for more information.

Health Flexible Spending \$_____ (Max \$3,000 per household)

Dependent Care Flexible Spending \$_____ (Max \$3,000 per household)

Mesa Choice Health Plan

Coverage Options & Eligibility

All full-time employees are eligible to enroll in one of the health plans offered through the Mesa Choice Health Plan.

Who Are My Eligible Dependents?

- Legal spouse;
- Natural children;
- Legally adopted children, or children for whom you/your spouse are a court-appointed guardian;
- Stepchildren who reside with you.

Enrolling Dependents:

If you choose Family Coverage you MUST submit copies of the following documents as applicable to the Employee Benefits Office BEFORE coverage begins:

- Marriage Certificate, if enrolling a spouse.
- Birth Certificates, adoption documents or other court documentation verifying legal guardianship, if enrolling one or more dependent children.
- Step Children - Natural parent's divorce decree (if applicable) **and** a written statement from our employee indicating the stepchild lives with him/her full time, if enrolling one or more stepchildren who lives with you so we can verify primary/secondary coverage status.
- Insurance card/proof of insurance, if you or your dependents are covered under another health insurance plan.
- Verification of full-time student status for dependent children ages 19-23. A reinstatement fee of \$100 is assessed if full-time student verification is received after the deadline.

Dependent children are eligible until the end of the month following their 19th birthday. However, if children are under age 23, unmarried, and attending school on a full-time basis, or are participating in a religious excursion, they may continue to be covered as long as they continue to meet this requirement. At age 23, dependent children are no longer eligible for coverage as your dependents unless they are disabled and unable to maintain self-sustaining employment because of their disability.

Effective 1/1/2010, if the City of Mesa Employee Benefits Office receives a written certification from a covered child's treating physician that the child is suffering from a serious illness or injury, AND that a leave of absence (or other change in enrollment) from a postsecondary institution is medically necessary, and the loss of postsecondary student status would result in a loss of health coverage under the Plan, the Plan will extend the child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the medically necessary leave of absence (or other change in enrollment) and ends on the date that is the earlier of (a) one (1) year later, or (b) the date on which coverage would otherwise terminate under the terms of the Plan.

Qualified Change to Family Status:

Our medical, dental, vision and flexible spending account (FSA) benefits are offered on a pre-tax basis. Because the IRS is giving employees a tax advantage, there are certain rules governing those benefits. One of those rules is that once you make your benefit elections, you cannot change them during the plan year unless you have a Qualified Change in Family Status. If you have a Qualified Change in Family Status as identified by IRS rules, you can make a change that is consistent with the status change, which may include enrolling in or opting out of coverage, adding or removing dependents, and changing your FSA election. To do so, you must contact Employee Benefits within 30 days of the event. Otherwise, you must wait until the next open enrollment.

IMPORTANT NOTICE REGARDING ENROLLMENT: If you have or anticipate a Family Status Change (i.e., newborn, marriage, divorce, or adoption) that becomes effective after your benefit effective date please contact the Employee Benefits Office **immediately** at (480) 644-3329.

Members Who Opt Out of Coverage

If you are a full-time employee who opts out of coverage, you must provide verification each year that you are covered under another health insurance plan. This verification may take the form of a copy of your health insurance card or enrollment form from the other health plan.

myhealthIQ

The City's New Wellness Program

The City has recently launched a new Wellness Program called myhealthIQ. This program is administered by OptimalHealth (a division of Healthways) and includes both a brief Health Risk Assessment Questionnaire and Physical Assessment. New employees will be given an opportunity to participate in the future, approximately mid-year of 2010.

Mesa Choice Medical Plan

Our entire health insurance program is self-insured and self-administered, with Blue Cross Blue Shield of Arizona (BCBSAZ) as our network provider. **All BCBSAZ providers are considered in-network for all of the City's Medical Plans.** Claims are sent to and processed by the City of Mesa Employee Benefits Office. Members may choose between four different medical plans depending upon their individual needs.

The four medical plans offered are:

- **Choice PPO Plan: 80/20*** - This plan features 80/20 coverage after the \$300 deductible has been met for in-network services.
- **Choice Plus PPO Plan: 90/10*** - This plan provides additional coverage (90/10 coverage, \$200 deductible in-network) at a higher premium.
- **Basic Choice Plan: 50/50*** - This plan offers catastrophic coverage for the individual with few medical expenses.
- **Copay Choice Plan*** - This plan is similar to an HMO plan. \$20 copay for office visits, \$50 for Urgent Care, \$100 for Emergency Room services, \$100 for Outpatient and \$200 for Inpatient hospitalizations.

*See pages 10-11 for a summary of coverage or refer to the City of Mesa Plan Document at www.mesachip.org for detailed descriptions of covered and non-covered services.

Instructions for Locating a Blue Cross Blue Shield of Arizona Provider

Members enrolled in any of the Choice Medical Plans may choose a BCBSAZ contracted provider. Provider discounts vary based upon the provider's contract with BCBSAZ.

Using the Blue Cross Blue Shield of Arizona Website

Follow the instructions below to locate a medical provider in the BCBSAZ network.

1. On the web go to the website at www.azblue.com
2. A Guest page will appear. Click on "**Search the Provider Directory**" link.
3. On the "Health & Dental Provider Directory" page, under the ID card sample that says "Acme Company," click on the **Search** button. Do **not** click on the Search button that asks you for the 3-character alpha prefix.
4. Regardless of the Plan in which you are enrolled, select "PPO"
5. Click, "Next." Search options will follow.

We strongly encourage you to access the website for the provider directory. The website is updated monthly by BCBSAZ, listing any new providers, or removing those who have terminated recently.

If you need a printed Provider Directory, please contact Employee Benefits at (480) 644-2299.

Medical Premiums

Premiums for the four medical plans have been determined based upon the value of the individual plan. Premiums are deducted on a pre-tax basis, which means your premium payments/deductions are made from your paychecks before federal, state, and FICA taxes are calculated. Therefore, your taxable income is lowered and you pay less income tax.

Your health insurance premiums are deducted from the first two paychecks each month and are deducted one month in advance. Whenever there is a third paycheck in a month, no premiums are deducted. These deductions are itemized below:

CHOICE PPO PLAN (80/20)				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$305.00	\$274.50	\$ 30.50	\$15.25
Family	\$840.00	\$672.00	\$168.00	\$84.00
CHOICE PLUS PLAN (90/10)				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$ 500.00	\$274.50	\$225.50	\$112.75
Family	\$1,250.00	\$672.00	\$578.00	\$289.00
BASIC CHOICE PLAN (50/50)				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$274.50	\$274.50	\$0.00	\$0.00
Family	\$672.00	\$672.00	\$0.00	\$0.00
COPAY CHOICE PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$ 355.00	\$274.50	\$ 80.50	\$ 40.25
Family	\$1,000.00	\$672.00	\$328.00	\$164.00

Coverage for Emergency Services Outside Network Area

All plans provide coverage for emergency services incurred while traveling outside the network area.

In the event of an emergency as defined in the Plan Document, the initial emergency visit will be covered as in-network; however, all follow-up visits and services will be considered based upon the provider's network status at the time services are rendered. If you have an accident, whether at home or elsewhere, the initial visit will be covered as in-network. Any aftercare must be provided by a BCBSAZ provider or facility to be paid as in-network. If you have dependents who live outside Arizona and have an accident, whether at home or elsewhere, the initial visit will be covered as in-network. Any aftercare must be provided by a provider who is contracted with HealthSmart (or in some instances, Beech Street) to be considered in-network.

Out-of-Network Coverage

The Health Plan does not cover out-of-network charges (both in-state and out-of-state) as in-network, except in emergency situations.

If you are scheduled for a surgical procedure, it is **your** responsibility to ensure that **ALL** providers involved (such as the surgeon, anesthesiologists, assistant surgeons, and the healthcare facility) are in-network providers. In some case, the Benefits Office will negotiate with out-of-network anesthesiologists and assistant surgeons, but there is no guarantee that these charges will be considered in-network.

When an individual uses an out-of-network provider, the health plan does not receive any discounts. In some instances, especially in cases of hospitalizations and surgeries, this can be very costly to the Employee Benefit Trust. It is important that you choose in-network providers in order to get your best benefit.

Out-of-State Plan Members

If you have dependents who reside outside of Arizona, your dependents are eligible to receive in-network benefits by using providers contracted with HealthSmart (or in some cases, Beech Street). See page 14 for more details.

Out of Pocket Maximum (In-Network)

The Out of Pocket Maximum refers to the total amount of coinsurance (not including deductibles and copays) that you have to pay before the health plan covers the rest of your expenses at 100% for the remainder of the calendar year. For example, if you are enrolled in the Choice PPO Medical Plan, your in-network, out-of-pocket maximum is \$2,000 per person. Each time an in-network claim is processed by the health plan, your portion of the cost is applied to this \$2,000 out of pocket maximum amount. When the in-network out-of-pocket maximum reaches \$2,000 in our claims processing system, the plan will pay your covered medical claims at 100% for the rest of the calendar year. See pages 10-11 for out-of-pocket

maximums for the other plans and for out-of-network services. Certain services do not accumulate to meet the out-of-pocket maximum. Please refer to the Plan Document for details.

Remember... there is no Out-of-Pocket Maximum for services rendered by Out-of-Network providers when those same services could have been provided by an In-Network provider.

Precertification and Utilization Review/Case Management

Under all City of Mesa Medical Plans, certain covered services require precertification. Precertification is the process used by the Utilization Management Company, under contract by the City, to ensure that hospitalizations, surgeries, and other procedures are medically necessary.

Utilization (or Concurrent) Review/Case Management is the process used to ensure that continuation of medical services is medically necessary, and to coordinate your care with other health care providers, such as home health agencies, durable medical equipment vendors, and others. The Utilization Review Coordinator or Case Manager may also assist with discharge planning and advising your medical providers of various options available under your plan. These services are offered at no cost to you.

American Health Group is our precertification, utilization review and case management company. Often, your physician's office will contact them on your behalf to precertify these types of services. **However, you are ultimately responsible for making sure services have been precertified.**

To precertify any of the above services, or for more information about services that require precertification, call American Health Group at (602) 265-3800 or 1(800) 847-7605. **Failure to precertify will result in a reduction in benefits payable, which will increase the amount you have to pay.**

The following services are examples of those procedures that require precertification:

- All elective non-emergency admissions, except for birth of a baby;
- All elective admissions to specialized facilities, including outpatient surgical centers, hospice, skilled nursing facilities, and subacute care facilities;
- All admissions to inpatient or day treatment rehab facilities for both medical and mental health services;
- Colonoscopies, except those covered under the Routine Colonoscopy Benefit (See page 11); any other invasive diagnostic tests;
- Sleep studies;
- Durable Medical Equipment with a cost of \$1000 or more;
- **Emergency admissions must also be precertified within 48 hours after admission.**

Non-Covered Services

There are certain services that are not covered under the City of Mesa Medical Plans. Below are some of the services that are not covered. Please note: This list is not all-inclusive. If you have a question as to whether or not a specific service is covered, please consult the Plan Document or contact the Benefits Office.

- Cosmetic surgery or related expenses;
- Fertility treatment, except limited services available under the Choice Plus PPO Plan;
- Health club memberships;
- Massage therapy, except when performed by a physical therapist or chiropractor;
- Medications not approved by the FDA;
- Nutritional supplements and/or vitamins (except prenatal vitamins);
- Services that are experimental and/or investigational in nature;
- Smoking cessation or tobacco withdrawal;
- Vision services, except exams and lenses required following cataract surgery;
- Weight management programs, such as Weight Watchers or Jenny Craig.

For more detailed information about services that are not covered, please contact Employee Benefits at (480) 644-2299 or refer to the Plan Document found at www.mesachip.org.

Other Insurance Coverage

If you or your dependents are covered by another health insurance policy, you need to submit a copy of your insurance card from the other carrier to the Employee Benefits Office, who will use this information to determine which plan is primary (i.e. which plan pays first). There are certain rules that determine which plan is primary. For assistance with determining which of your insurance carriers is primary, please contact Employee Benefits at (480) 644-2299.

NOTE: If your dependent has other insurance that is primary AND has copays, please be advised that the City of Mesa plan does not coordinate benefits with copays.

Your Insured ID Number (Employee/Insured ID)

You're Employee ID number and Insured ID number are the same 5 digit number. When filling out forms at your healthcare provider's office, please use your 5-digit ID number found on your insurance card as your Insured ID number.

Always take your healthcare ID card with you when you visit a healthcare provider. To ensure your claims are processed properly, it is very important to use the 5-digit identification number that is on your card. Using the incorrect member ID and/or group number can delay the processing of your claim. Providers often submit claims with wrong identification numbers, and then continue to resubmit the claim incorrectly. **If your claims are not submitted with the correct information, they may be denied until they are submitted correctly.**

Note: Your medical card is combined with your prescription drug card and comes to you from Medco. Please order replacement cards through the Medco website.

MESA CHOICE HEALTH PLAN 2010 HIGHLIGHTS* - MEDICAL

	CHOICE PPO PLAN \$ 30.50 Monthly - Single \$168.00 Monthly - Family		CHOICE PLUS PPO PLAN \$225.50 Monthly - Single \$578.00 Monthly - Family		BASIC CHOICE PLAN No Premium for Single or Family coverage		COPAY CHOICE \$ 80.50 Monthly - Single \$328.00 Monthly - Family	
Medical Services	In-Network PPO & Par Providers	Out-of-Network	In-Network PPO & Par Providers	Out-of-Network	In-Network PPO Providers Only	Out-of - Network	In-Network PPO Providers Only	Out-of-Network
Deductible per calendar year	\$300 per person; \$900 per family	\$1000 per person; \$3000 per family	\$200 per person; \$600 per family	\$1000 per person; \$3000 per family	\$550 per person; \$1650 per family	\$1000 per person; \$3000 per family	None	\$1000 per person; \$3000 per family
Hospital Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$100 copay OP; \$200 copay IP	After deductible, 60%
Physician & Health Care Practitioner Services	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	\$20 copay for sick OV, all other 50% after deductible	After deductible, 25%	\$20 copay	After deductible, 60%
Chiropractic Manipulations – 25/calendar year	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Rehab Services	Rehab Services include physical therapy, occupational therapy, speech therapy, and chiropractic modalities.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
X-Ray, Diagnostic	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No deductible, 100%	After deductible, 60%
Emergency Room	After deductible, 80%	After deductible, 80%	After deductible, 90%	After deductible, 90%	After deductible, 50%	After deductible, 50%	\$100 copay, (Waived if admitted)	\$100 copay (Waived if admitted)
Urgent Care Facility	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$50 copay	After deductible, 60%
Durable Medical Equipment (DME)	Includes DME rentals and purchases. DME over \$1000 requires precertification through American Health Group. Maximum payable per calendar year is \$5000.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Foot Orthotics	Limited coverage for molded shoe orthotics prescribed and customized by a physician. Charges subject to appropriate deductibles, coinsurances and copays based on plan selected. \$500 maximum payable per calendar year.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Well Child Care and Immunizations	Birth - Age 2: \$1000 maximum payable per calendar year				Age 3-18: \$400 maximum payable per calendar year			
	After deductible, 80%	Not Covered	After deductible, 90%	Not Covered	After deductible, 50%	Not Covered	\$20 copay	Not Covered
Out of Pocket Maximum	\$2000 per person	None	\$1000 per person	None	\$5000 per person	None	None	None

*This chart is a summary of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document, available at www.mesachip.org or Employee Benefits. –continued-

MESA CHOICE HEALTH PLAN 2010 HIGHLIGHTS – MEDICAL* (continued)

	CHOICE PPO PLAN \$ 30.50 Monthly - Single \$168.00 Monthly - Family		CHOICE PLUS PPO PLAN \$225.50 Monthly - Single \$578.00 Monthly - Family		BASIC CHOICE PLAN No Premium for Single or Family coverage		COPAY CHOICE \$ 80.50 Monthly - Single \$328.00 Monthly - Family	
Medical Services	In-Network PPO & Par Providers	Out-of-Network	In-Network PPO & Par Providers	Out-of-Network	In-Network PPO Providers Only	Out-of-Network	In-Network PPO Providers Only	Out-of-Network
Well Adult Care	\$400 annual maximum payable per calendar year, not subject to deductible. Services include well man and well woman services, office visits, pap smears, mammograms, PSA, fecal occult tests, routine physical exams, lab tests, chest x-ray, immunizations, colon cancer screening, and routine EKG.							
	80%	60%	90%	70%	50%	25%	\$20 copay	60%
Routine Colonoscopy for Members Age 50+	Covered at 100% of in-network allowable rates once every 10 years. Payable benefits include professional fees, facility fees, and pathology fees. Member MUST use in-network BCBSAZ providers (HealthSmart for out-of-state members). This benefit is not subject to deductible or the Well Adult Care maximum.							
	100%	Not Covered	100%	Not Covered	100%	Not Covered	100%	Not Covered
Voluntary Sterilization	Includes vasectomies, tubal ligations & other voluntary (non-medically necessary) sterilization procedures. Note: Procedure must be performed by a BCBS in-network provider to be considered.							
	After deductible, 50%	Not Covered	After deductible, 50%	Not Covered	After deductible, 50%	Not Covered	No deductible, 50%	Not Covered
Allergy Services (testing, physician visits)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Allergy Services (injections only)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$5 copay	After deductible, 60%
Allergy Services (Injections with office visit)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Allergy Services with no copay (i.e., serum)	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	No copay	After deductible, 60%
Alternative Health Care (Acupuncturists, Naturopaths, Homeopaths)	After deductible, 80% up to \$1000/year	After deductible, 60% up to \$1000/year	After deductible, 90% with no annual max	After deductible, 70% with no annual max	Not Covered	Not Covered	Not Covered	Not Covered
Behavioral/ Mental Health Office Visits	Includes visits with psychiatrist, psychologist, or other MH provider, counseling session & psych testing. A maximum of 25 visits allowed per calendar year.							
	After deductible, 80%	After deductible, 60%	After deductible, 90%	After deductible, 70%	After deductible, 50%	After deductible, 25%	\$20 copay	After deductible, 60%
Out of Pocket Maximum	\$2000 per person	None	\$1000 per person	None	\$5000 per person	None	None	None

*This chart is a **summary** of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document, available at www.mesachip.org or Employee Benefits.

Prescription Benefit

Outpatient Prescription drug benefits are available through the Plan's prescription drug network, Medco. For locations of the network pharmacies or information on which types of drugs are covered, contact Medco at 1(800)711-0917 or visit their website at www.medco.com. (You must have a valid e-mail address to register as a member.)

If a generic drug is available and the member or physician refuses substitution to generic, the member will pay the appropriate percentage or copay PLUS the difference in cost between the generic and brand name drug.

For certain Maintenance Medications, after the third refill at retail, Medco may send the member a letter recommending that maintenance medications be filled through the Mail Order Pharmacy. If members do not want to use the Mail Order Pharmacy for these medications, the Retail copay will be doubled and the coinsurance will increase by another 5%. Minimum and Maximum copays will also be increased.

For the Choice, Basic, and Choice Plus Plans, Brand Name drugs for which there is no generic equivalent will be subject to the appropriate Brand Name Coinsurance. They will not be payable at the Generic rate.

Note: Most, if not all prescription drugs are covered under this plan, including injectables and specialty medications. If you are told by your pharmacy that Medco is not covering your prescription, please contact the Benefits Office to confirm this to be true. It's possible your prescription may simply require prior authorization, which is usually quick and easy to do. We highly recommend you purchase all medications through Medco whenever possible, especially expensive, specialty medications.

A Word About Walmart...and Target...and Fry's...and now Basha's: Many of the retail pharmacies are offering generic medications for \$4 per month for a 30 day supply, and \$10 per month for 90 days. We highly recommend you take advantage of these low-cost prescriptions whenever possible. Please note: the \$4 (or \$10) you pay **IS NOT** reimbursable through the Employee Benefit Trust Fund.

Please review the charts below for each of the plans:

Choice and Choice Plus Plans	Annual Deductible per Person	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-day Supply				
Member Pays	\$50.00	20%	25%	40%
Minimum Copay per Rx		\$5.00	\$25.00	\$35.00
Maximum Copays per Rx		\$50.00	\$100.00	\$100.00
Maintenance Meds* not filled by Mail: Mbr Pays	\$50.00	25%	30%	45%
Increased Min Copay		\$10.00	\$50.00	\$80.00
Increased Max Copay		\$100.00	\$200.00	\$200.00
*Not all Maintenance Medications are subject to these increases. Check with Medco for additional information.				
MAIL ORDER – Up to 90-Day Supply				
Member Pays	\$ 0.00	20%	25%	40%
Minimum Copay per Rx		\$10.00	\$50.00	\$80.00
Maximum Copays per Rx		\$100.00	\$200.00	\$200.00
**Single Source Meds (no generic alternative) covered as Formulary Brand or Non-Formulary Brand				

Copay Choice Plan	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-Day Supply			
Member Pays	\$15.00	\$35.00	\$65.00
Maintenance Meds* not filled by Mail: Mbr Pays	\$30.00	\$70.00	\$130.00
*Not all Maintenance Medications are subject to these increases. Check with Medco for additional information.			
MAIL ORDER – Up to 90-Day Supply			
Member Pays	\$30.00	\$70.00	\$130.00
**Single Source Meds (no generic alternative) covered as Formulary Brand or Non-Formulary Brand			

Basic Choice Plan	Annual Deductible per Person	Generic	Formulary Brand**	Non-Formulary Brand**
RETAIL – Up to 30-day Supply				
Member Pays	\$250.00	20%	25%	40%
Minimum Copay per Rx		\$5.00	\$25.00	\$35.00
Maximum Copays per Rx		\$50.00	\$100.00	\$200.00
Maintenance Meds* not filled by Mail: Mbr Pays	\$250.00	25%	30%	45%
Increased Min Copay		\$10.00	\$50.00	\$80.00
Increased Max Copay		\$100.00	\$200.00	\$400.00
*Not all Maintenance Medications are subject to these increases. Check with Medco for additional information.				
MAIL ORDER – Up to 90-Day Supply				
Member Pays	\$250.00	20%	25%	40%
Minimum Copay per Rx		\$10.00	\$50.00	\$80.00
Maximum Copays per Rx		\$100.00	\$200.00	\$300.00
**Single Source Meds (no generic alternative) covered as Formulary Brand or Non-Formulary Brand				

Non-Network Retail Pharmacy – No Discount

If you fill a prescription at an out-of-network, non-participating pharmacy location, you must pay for the drug at the time of purchase, then mail your drug receipt and claim form to the Medco Prescription Drug Program.

Reimbursement is based upon the amount that would have been charged by a participating pharmacy, less the appropriate retail coinsurance or copay listed above. Claim forms are available at www.medco.com.

For detailed information on prescription drug coverage, please refer to the City of Mesa Plan Document at www.mesachip.org.

Note: All City of Mesa Prescription Drug Plans are considered Creditable with Medicare Part D. The Notice of Creditable Coverage is included in this workbook starting on page 33

Medical Coverage for Out-of-State Members

The City of Mesa is contracted with HealthSmart PPO* to provide an out-of-state network for those health plan members who live outside the State of Arizona to help you and the Employee Benefit Trust save money on your health care needs.

The HealthSmart PPO* network includes a variety of providers throughout the United States, including hospitals, urgent care centers, family practice doctors and specialists.

This network is only for those covered persons who regularly live outside Arizona. **It is not for members who normally reside in Arizona who are traveling outside the state.** If you are a member or have an eligible dependent who is moving out-of-state, please notify the Benefits Office so we can enroll you in HealthSmart.

For out-of-state members who use a HealthSmart PPO* contracted provider, your services will be processed as in-network for the plan you selected. For example, if you are enrolled in the Choice Plus (90/10) plan, services rendered by a HealthSmart provider will first be subject to a \$200 per person annual deductible, then paid at 90%. You will be responsible for paying this deductible and the 10% coinsurance.

If you use a non-network provider as a Choice Plus member, your services will be processed as out-of-network (subject to a \$1000 deductible, then paid at 70%). (If you have another insurance as your primary carrier, covered services will be paid as **in-network**. See below.)

If you are having a surgical procedure, hospitalization, receiving durable medical equipment over \$1000, or receiving home health care, these types of services still need to be precertified by American Health Group at (602) 265-3800 or 1 (800) 847-7605.

If the City of Mesa is your primary or only carrier, present your HealthSmart PPO* card to the provider at the time of your appointment. The provider needs to send your claim to: HealthSmart, PO Box 53010, Lubbock, TX 79453-3010.

If you did not receive a card, please contact the Employee Benefits Office at (480) 644-2299 or via e-mail at benefits.info@cityofmesa.org. Please give the provider your 5-digit ID number as the Insured ID-number.

If the City of Mesa is your secondary carrier, inform the provider that you have primary insurance. After the primary insurance has processed the claim, send the itemized bill with the primary carrier's Explanation of Benefits to: City of Mesa Employee Benefits, PO Box 1818, San Leandro, CA 94577.

Providers should still call Employee Benefits at (480) 644-2299 to verify coverage, if necessary.

Instructions for Finding a HealthSmart Provider (for Out-of-State Residents Only)

1. Go to www.healthsmart.net.
1. Click on the "Patient/Policy Holder" button at the top.
2. Click on the "Provider Directory" link on the left.
3. Click on the "searches" link in the first paragraph in the middle.
4. In the "Search" box, click on "Yes" to agree to the disclaimer.
5. Enter CM002 as the group number. The screen will refresh.
6. Under Group Number, click on the CM002 link.
7. Click "Ok" on the pop-up button.
8. Click on the search option of your choice.

If you have questions or problems with finding a provider, please contact our office for assistance. You can also call HealthSmart directly at 1(800) 687-0500 to find a provider.

**In some states, HealthSmart PPO has also contracted with BeechStreet PPO to provide expanded network services. Members living in Arkansas, Louisiana, Mississippi, New Mexico, Oklahoma, Texas, and Tennessee can only use HealthSmart PPO (not Beech Street) providers to be considered as in-network. Beech Street PPO does not contract with HealthSmart PPO in these states.*

Choosing the Plan That's Best for You and Your Family

We are often asked, "How do I know which plan to choose?" This section includes some information for you to consider as you make your health insurance plan decisions.

First, take a look at the member premium costs to determine which of the plans will fit within your family's budget. Remember, health insurance premiums are deducted on a pre-tax basis, so at the end of the year when you are getting ready to submit your income tax statements, you CANNOT use the premiums you pay as deductions.

Next, take a look at your health care expenses during the last calendar year. How much are you actually USING your benefits? If you're pretty healthy and don't go to the doctor a lot, or you don't have any chronic conditions that require a lot of medication, then you probably don't need to be enrolled in the most expensive plan just because it's convenient. On the other hand, if you or one of your family members has been quite ill, has a chronic condition or has made numerous visits to the hospital, it might make more sense for you to be enrolled in one of the more expensive plans, like the Copay or Choice Plus. These plans pay more toward hospitalizations and surgeries, but they come with a higher price tag

In other words...do the math! Add the amount you pay in premiums to the amount you have paid for medical services, including prescription drugs, and compare that to what you would have paid for those same services under one of the other plans.

Don't forget to include the cost of prescription drugs when determining your actual health care out of pocket expenses – use your pharmacy receipts from both the local retail and mail order pharmacies. This information will help you see just how much you have spent towards your healthcare over and above your monthly premiums, and will also help you decide whether or not you are enrolled in the right plan.

Another thing to keep in mind: Some of the plans have maximum out-of-pocket amounts that apply to each person enrolled in your plan. For example, on the Choice PPO 80/20 plan, the maximum out-of-pocket (not including deductibles) is \$2000 per person in-network. This means that in any calendar year, you will pay no more than \$2300 (the maximum out-of-pocket plus deductible) toward your medical expenses; after that, the health plan will pay 100% until the end of the calendar year. Remember, prescription drugs are not included in this out-of-pocket maximum, so those have to be considered separately.

Finally, think about what medical or dental procedures might be occurring during the coming plan year. If you suspect that one of your family members is going to have surgery, or perhaps someone needs a crown or root canal, or one of your kids is in need of braces for their teeth, then you need to take these into consideration when choosing your plan for the coming year. Check the coverage summaries: not all services are covered under all plans. For example, under dental, only the Dental Choice Plus plan covers orthodontia for dependent children...none of the other dental plans have this coverage, so if your child is going to need braces, you MUST be enrolled in Dental Choice Plus for them to be covered.

Maximizing Your Healthcare Benefits

Here's what you can do to maximize your benefits, while still saving money for yourself and the Employee Benefit Trust:

- Choose In-Network PPO providers. Make sure **ALL** providers involved in your care are in the Blue Cross Blue Shield of Arizona network if you live in Arizona. If you live outside of Arizona, use HealthSmart PPO network providers.

If you are scheduled for a surgical procedure, do your best to ensure that **ALL** providers involved (such as the surgeon, anesthesiologist, assistant surgeons, and the healthcare facility) are in-network providers.

When you use an out-of-network provider, there are no discounted rates. Even though the provider may be willing to reduce YOUR cost, the cost to the City is still higher, even with a lower benefit. Sometimes out-of-network providers will not charge you more than your estimated in-network copay or co-insurance. Keep in mind that the City does not receive a discount on these expenses. Therefore, the Employee Benefit Trust is financially responsible for the cost of your care, which in most cases, is significantly higher.

- Choose generic medications whenever possible. Not only will you get a better benefit, but it will also be less expensive for the plan. Currently, the City pays \$250,000 or more every two weeks in prescription drug costs. The more our members choose generic, the better it will be for everyone.
- Use the mail order pharmacy for your medications you take regularly. When we use the mail order pharmacy, the City receives a greater discount on each drug from Medco, our pharmacy benefit manager. The dispensing fee lessens as well – 65 cents per prescription instead of as much as \$3.50 at the retail pharmacy.

Mail order is also convenient to use. At your next doctor's appointment, have your doctor write you two prescriptions: One for a 30-day supply to have filled at the retail pharmacy, and one for a 90-day supply to send to Medco By Mail. Pick up a Mail Order Claim form at the Benefits Office or go online at www.medco.com and print one off their website. Send the prescription and the form (along with your estimated payment or credit card number) to the address on the form. Your first prescription will usually be delivered in about 14 days. To request refills, contact Medco either online or by phone at (800) 711-0917. Your refills will be delivered to your mailbox within 5-7 days.

- Ask your doctor about possible alternatives to the more expensive brand name medications. Exceptions may be made for members who absolutely cannot take a different medication as verified by their doctor, but we as consumers of health care may need to do some cost comparisons. If there is a less expensive medication that will give you the same results, buy it.
- Enroll in the Health Care Flexible Spending Account (FSA). An FSA is a great way to reduce your tax liability on health care-related expenses that you might otherwise be unable to deduct from your taxes. For those who have an immediate qualifying expense, it acts like a no-interest loan. You receive the money up to your elected amount when the expense is incurred, even if you do not have the full amount in your FSA account. Expenses such as medical and dental deductibles, copays, and coinsurances are eligible for reimbursement. In addition, certain grocery stores and pharmacies are noting on their receipts which items may be considered on your FSA account. Review your receipt next time you purchase over-the-counter medications.

Mesa Choice Dental Plan

The Dental Plans available under the Mesa Choice Plan are self-insured and self-administered. You may choose any dental care provider. There are no in-network or out-of-network provisions under these plans. Claims are processed by the City of Mesa Benefits office.

Members have three plans from which to choose based upon their individual and family needs. The dental plans are:

- **Preventative Choice Plan** – Provides coverage for preventative services and limited restorative care (basic restorative care only). Orthodontia is NOT covered.
- **Dental Choice Plan** – Provides preventative, basic, and major restorative coverage. Orthodontia is NOT covered.
- **Dental Choice Plus Plan** – Provides additional coverage, INCLUDING orthodontia for dependent children under age 19. (No adult orthodontia coverage.)

Dental Premiums

Premiums for the three dental plans have been determined based upon the value of the individual plan. Premiums are deducted one month ahead on a pre-tax basis. The monthly premiums are as follows:

DENTAL CHOICE PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck*
Single	\$95.00	\$85.50	\$9.50	\$4.75
Family	\$170.00	\$136.00	\$34.00	\$17.00
DENTAL CHOICE PLUS PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck*
Single	\$110.00	\$85.50	\$24.50	\$12.25
Family	\$250.00	\$136.00	\$114.00	\$57.00
PREVENTATIVE CHOICE PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck*
Single	\$85.50	\$85.50	\$0.00	\$0.00
Family	\$142.00	\$136.00	\$6.00	\$3.00

Non-Covered Dental Services

As with the medical plan, there are certain services that are not covered under any of the dental plans. They include:

- Expenses exceeding the Allowed amount (see below);
- Orthodontia for children under age 19 that started **before** benefits began with the City of Mesa;
- Analgesia, sedation, hypnosis, nitrous oxide and/or related services provided for apprehension or anxiety, except when approved by the Plan Administrator;
- Cosmetic services, including but not limited to veneers and facings;
- Drugs and medicines;
- Duplication of dental services by another provider;
- Home use supplies, such as dental rinses, toothpaste, fluoride, etc.;
- Dental Implants;
- Athletic mouth guards;
- Oral hygiene or dietary instructions;
- Orthognathic services;
- Periodontal splinting;
- Sealants for adults.

For more detailed information about services that are not covered, please refer to the Plan Document found at www.mesachip.org or contact Employee Benefits at (480) 644-2299.

MESA CHOICE HEALTH PLAN 2010 HIGHLIGHTS – DENTAL

DENTAL SERVICES	PREVENTATIVE CHOICE PLAN No Monthly Premium for Single \$6.00 Monthly - Family	DENTAL CHOICE PLAN \$ 9.50 Monthly - Single \$34.00 Monthly - Family	DENTAL CHOICE PLUS PLAN \$ 24.50 Monthly - Single \$114.00 Monthly - Family
Deductible per calendar year	\$100/person; \$300/family Applies to restorative care only	\$100/person; \$300/family Applies to restorative care only	\$100/person; \$300/family Applies to restorative care only
Preventative visits Include exam, tooth cleaning, bitewing x-rays; Full mouth/panoramic x-rays limited to once every 36 months. (Excludes periodontal cleanings & services)	Not subject to deductible 100%	Not subject to deductible 100%	Not subject to deductible 100%
Basic Restorative (sealants*, fluoride, fillings, extractions) *Coverage limited to dependent children under age 19 only	After deductible, 80%	After deductible, 80%	After deductible, 80%
Major Restorative (crowns, bridges, root canals, dentures, oral surgery, periodontia, & endodontia)	Not Covered	After deductible, 80%	After deductible, 80%
Orthodontia** **Coverage applies only to dependent children under age 19	Not Covered	Not Covered	No Deductible, 80% Coverage, \$1200 Maximum Payable/Year \$2400 Maximum Payable Lifetime
Annual Maximum Payable for Dental Services	\$500 per person	\$1200 per person	\$1500 per person

This chart is a summary of how eligible services will be covered. For a complete list of services and more detailed information, please refer to the City of Mesa Health Plan Document at www.mesachip.org or from Employee Benefits.

Allowed Charges

ALL dental charges that are submitted to the Benefits Office are compared to a schedule of allowed charges before they are processed. If the charges for services rendered are higher than the Allowed amount for the provider's location (by zip code), benefits will be paid based on the lower Allowed Amount and the patient will be responsible for paying the difference between the billed charge and the lower R&C amount. "Allowed" Amounts should not be confused with "Contracted" Amounts: When an Allowed Amount is applied, the patient is responsible for the difference between the Billed Charge and the Allowed Amount. When a Contracted Amount is applied, the patient IS NOT responsible for the difference between the two. Because the City of Mesa's Dental Plan is not associated with a network, there are no Contracted Amounts for services rendered.

How can you avoid paying more than the Allowed Amount for your dental services? Have your provider submit a Predetermination of Dental Benefits form to the Employee Benefits Office BEFORE services are rendered. The Benefits Office will process the Predetermination as if it were a regular claim, indicating any amounts over the Allowed Amount as well as the amounts to be applied to any deductibles and coinsurance amounts for which the patient is responsible. This is a good way for you to know ahead of time how much your financial responsibility will be when you have dental services that need to be completed.

Mesa Choice Vision Plan

Vision care benefits are provided by Vision Service Plan (VSP). The City offers its members two types of plans.

- **Basic Vision** – Offers basic coverage at a nominal cost.
- **Vision Plus** – Offers additional coverage for a higher monthly premium.

Select a Participating Provider at www.vsp.com or call 1-800-877-7195.

BASIC VISION PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$4.86	\$4.35	\$.51	\$.26
Family	\$13.42	\$6.79	\$6.63	\$3.32
VISION PLUS PLAN				
	Total Premium	City Contribution	Employee Contribution	Per Paycheck
Single	\$8.30	\$4.35	\$3.95	\$1.98
Family	\$22.88	\$6.79	\$16.09	\$8.05

IN-NETWORK BENEFITS USING A VSP PROVIDER		
	BASIC VISION PLAN 12/24/24	VISION PLUS PLAN 12/12/12
Comprehensive Vision Exam	\$10 copay, once every 12 months	\$10 copay, once every 12 months
Materials	\$10 copay, once every 24 months	\$10 copay, once every 12 months
The materials copay is a single payment that applies to the entire purchase of eyeglasses (lenses and frames), or contacts in lieu of eyeglasses.		
Pair of Lenses for Eyeglasses	Once every 24 months	Once every 12 months
<ul style="list-style-type: none"> • Standard single vision • Standard lined bifocal • Standard lined trifocal 	Covered in Full Covered in Full Covered in Full	Covered in Full Covered in Full Covered in Full
Lens Options		
<ul style="list-style-type: none"> • Standard Scratch Coating • Tints • Polycarbonate Lenses* • UV Coating • Basic Progressive Lenses 	Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount	Available at a discount Available at a discount Available at a discount Available at a discount Available at a discount
*Covered in Full for Children under 18		
Lens options not covered by the plan may be available at a discount		
Eyeglass Frames	Once every 24 months receive a \$130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.	Once every 12 months receive a \$130 retail frame allowance PLUS 20% discount off amounts over the retail allowance.
Contact Lenses in lieu of Eyeglasses (Lenses & Frames)	Once every 24 months	Once every 12 months
Covered in full elective contact lenses <ul style="list-style-type: none"> • \$200 Allowance in lieu of lenses and frames • Member receives 15% discount off doctor's professional fees for Contact Lens fitting and evaluation 	\$200 allowance once every 24 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.	\$200 allowance once every 12 months. Fitting/evaluation is offered at a 15% discount. If a member chooses a contact lens not currently part of the Contact Lens Care Program, they have the flexibility to use their elective contact lens allowance any way they choose. The allowance can go toward contact lens services and contact lenses. Members will always receive 15% off all contact lens services from their VSP doctor. VSP covered contact lenses may vary by provider.
Medically Necessary Contacts Lenses <ul style="list-style-type: none"> • \$250 Allowance 	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 24 months	Applies to individuals who cannot wear eyeglasses because of a medical condition, allergy, etc. Covered once every 12 months
Refractive Eye Surgery- Member may receive approximately 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities. Check the VSP website at www.vsp.com for more information.		

BENEFITS USING AN OUT-OF-NETWORK PROVIDER

Reimbursement frequency is based on plan selected (Basic Vision or Vision Plus)

SERVICE	AMOUNT	SERVICE	AMOUNT
Exam		Lenses	
• Optometrist	Up to \$40	• Single Vision	Up to \$40
• Ophthalmologist	Up to \$40	• Bifocal	Up to \$60
		• Trifocal	Up to \$80
		• Lenticular	Up to \$100
Contact Lenses (in lieu of eyeglasses)		Frames	Up to \$45
• Elective	Up to \$200		
• Necessary	Up to \$250		

TO FILE AN OUT OF NETWORK CLAIM:

Submit an itemized receipt with the covered member's ID number, name, address, phone number, patient's date of birth and relationship to member to the following address:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

Be sure to write on your receipt "City of Mesa Vision Plan"

Limitations and Exclusions

This plan is designed to cover eye examinations and corrective eyewear. Benefits are payable only for expenses incurred while the group and individual member's coverage is in force.

The following services and materials are not covered under the Vision Service Plan:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Two pairs of glasses instead of bifocals
- Medical or surgical treatment of the eyes
- Replacement of lenses and frames furnished under this program, except at the normal intervals when services are available

The following items are not covered under the VSP Plan contact lens coverage:

- Corneal Refractive Therapy (CRT) or Orthokeratology
- Replacement of lost or damaged lenses
- Insurance policies or service agreements
- Plano lenses (i.e. refractive error less than +/- 0.50 diopter power)
- Artistically painted lenses
- Additional office visits associated with contact lens pathology
- Contact lens modification, polishing or cleaning

Many services are available at discounted rates. Check with your vision care provider or the Vision Service Plan website at www.vsp.com.

Mesa Choice Flex Plan

The Mesa Choice Flex Plan offers you the opportunity to set aside pre-tax dollars from your paycheck to pay for certain eligible health care and/or dependent care (child or elder care) expenses that would normally be paid out of your own pocket. When you enroll in the flexible spending account program, you reduce your tax liability by reducing your taxable income.

Health Flexible Spending Account

The Health Flex plan allows you to set aside up to \$3,000 in 2010 to pay for eligible health care expenses that are not covered by your insurance. These expenses must be incurred by you or a qualified dependent. These include:

- Deductibles;
- Coinsurance;
- Copayments;
- Certain items not covered by insurance.

Dependent Care Flexible Spending Account

The Dependent Care Flex Plan allows you to set aside up to a maximum of \$5,000 per married couple or single adult in 2010 to pay for eligible child or elder care services that are needed so you and your spouse (if applicable) can work. Tuition for educational expenses (whether private or public) for children in kindergarten to age 13 is not eligible for reimbursement. Once you incur expenses for certain qualifying childcare expenses, you can submit those receipts to Employee Benefits for reimbursement from this account. The claims will be reviewed for eligibility and accuracy. Reimbursements made from this account will be equal to the amount of the claim, but not more than the amount currently in your Dependent Care Account. **This account is for day care expenses ONLY. You cannot claim dependent medical/dental expenses on the Dependent Care Flex Account.**

Dependent Care arrangements, which qualify include:

- A Dependent (Day) Care Center, provided it complies with applicable state and local laws if care is provided by the facility for more than six individuals;
- An education institution for pre-school children.
- For school-age children (Kindergarten through age 12), only expenses for before & after school care are eligible; tuition fees do not apply.
- An "individual" who provides care inside or outside your home who is not your child under age 19 or anyone you claim as a dependent for federal tax purposes (i.e., spouse).

Reimbursement for Expenses

If you receive reimbursement for an expense from one of the flexible spending accounts, you cannot claim that expense as a deduction or take a federal income tax credit on your personal income tax return.

Claims may be submitted for reimbursement up to 90 days after the end of a calendar year in which you are enrolled. The deadline to submit FSA claims for expenses incurred January 1, 2010 through December 31, 2010, will be March 31, 2011, by 5:00 p.m.

NOTE: When enrolling in the Flexible Spending Plan(s) for the first time, you should estimate your eligible expenses **carefully**: Any money left in your account after the reimbursement deadline will be forfeited and deposited into the Employee Benefit Trust.

BENEFITS EFFECTIVE DATE OPTIONS

As a new employee you have three benefit effective date options to choose to activate your CORE benefits.

ACTION WILL BE REQUIRED BY YOU TO ACTIVATE THESE BENEFITS

CORE Benefits include medical, dental, vision coverage and Mesa Choice Flex Plan enrollment.

Non-CORE Benefits include Basic Life Insurance, Voluntary Life Insurance and Voluntary Short Term Disability and **will be effective on the first of the month following one month of employment.**

Who Are My Eligible Dependents?

- Legal spouse
- Natural children
- Legally adopted children, or children for whom you/your spouse are a court-appointed guardian
- Step-children who reside with you

Dependent children are eligible until the end of the month following their 19th birthday. However, if children are under age 23 and attending school on a full-time basis, or are participating in a religious excursion, they may continue to be covered as long as they continue to meet this requirement. At age 23, dependent children are no longer eligible for coverage as your dependents unless they are disabled and unable to maintain self-sustaining employment because of their disability.

In order for you to activate your benefits, the following is a list of REQUIRED supporting documents that MUST accompany your benefit enrollment form:

- ☐ **MARRIAGE CERTIFICATE:** If you wish to provide health insurance for your spouse, submit/bring a copy of your marriage certificate.
- ☐ **DIVORCE DECREE:** If you (or your spouse) are divorced and are responsible for insurance for any dependent children, submit/bring a copy of you're the applicable divorce decree(s).
- ☐ **BIRTH CERTIFICATE:** When enrolling a dependent child, submit a copy of the child's birth certificate, adoption documents or other court documentation verifying legal guardianship of that child. When enrolling a stepchild who lives with you, please submit/bring a copy of the natural parent's divorce decree (if applicable) so we can verify primary/secondary coverage status.
- ☐ **CLASS SCHEDULE/RELIGIOUS EXCURSION DOCUMENTATION:** If you wish to provide health insurance for your unmarried dependent children age 19 but before their 23rd birthday, who are registered and attending classes as a full-time student, a copy of their class schedule must be provided initially on your first day, and each quarter or semester in the future. If the child is participating in a Religious Excursion, appropriate documentation from the church is required to continue coverage as a dependent.
- ☐ **COORDINATING BENEFITS:** If you or your dependent(s) are covered by another health insurance policy, you need to bring a copy of your insurance card from the other carrier.
- ☐ **OPTING OUT OF COVERAGE:** If you are not interested in participating in the offered plans, you will need to provide proof of outside coverage (insurance card, letter from carrier, etc.).

NOTE: DEPENDENTS CANNOT BE ADDED TO COVERAGE WITHOUT THESE DOCUMENTS. IT IS YOUR RESPONSIBILITY TO ENSURE THAT THEY ARE SUBMITTED TO EMPLOYEE BENEFITS.

OPTION ONE

Immediate Benefits

You may elect CORE benefits to become effective the day you begin employment with the City.

If you elect this option, you MUST complete and submit the benefits enrollment form along with any required supporting documentation to the Employee Benefits Office no later than **three working days** prior to your hire date. Employee Benefits must physically receive the enrollment form for your benefits to be effective on your hire date. If this documentation is not received as required, your benefits will be effective on the next available effective date. (Reference Option Two)

Medical and Dental Premium Calculation

CORE premiums are required to be paid one month in advance. Accordingly, it is important you know that should you choose this option for a benefit effective date, the following scheduled premiums will be deducted from your first paycheck:

- First month of coverage prorated from your hire date to the end of the month; **plus**,

Depending on your hire date:

- Either half or all of the second month; **AND**,
- Possibly the first half of the third month

Examples

If your hire date is 12/24/08 and you've selected this option, because your first paycheck will be on 1/10/09 the City will deduct from that paycheck premiums for:

- Remaining month of December + the entire month of January + first half of February

If your hire date is 1/7/09 because your first paycheck will be on 1/24/09 the City would deduct from that paycheck premiums for:

- Remaining month of January + the entire month of February

If your first check is not enough to cover the required premiums, the remaining amount due will be deducted from your second paycheck.

Vision Premium

Vision premium will be deducted for the entire month if you are hired on or before the 14th of the month. If your hire date is after the 14th of the month your coverage is effective on your hire date, however, there is no premium collected.

Submitting Required Paperwork

You can either drop off your benefit enrollment form, and Mesa Choice Flex Plan form (if applicable), accompanied by any required supporting documentation at the Employee Benefits Office located at 20 E. Main Street, Suite 600, Mesa, AZ 85201 **OR** mail them to:

Employee Benefits Administration
City of Mesa
P.O. Box 1466
Mesa, Arizona 85211-1466

If you mail the forms, it is your responsibility to follow up to make sure that the documents arrived within the above-specified time frame. You can check the status by calling the Employee Benefits Office at 480-644-3329.

OPTION TWO

First Of Month Following Employment

You may elect **CORE Benefits** to be effective the first of the month following your date of employment.

Hire Date	Benefit Effective Date	Hire Date	Benefit Effective Date
January 1-31	February 1	July 1-31	August 1
February 1-29	March 1	August 1-31	September 1
March 1-31	April 1	September 1-30	October 1
April 1-30	May 1	October 1-31	November 1
May 1-31	June 1	November 1-30	December 1
June 1-30	July 1	December 1-31	January 1

If you elect this option, and your employment begins the last week of the month you **MUST** complete and submit the Benefits Enrollment form, accompanied by any required supporting documentation and the Mesa Flex Plan form (if applicable) to the Employee Benefits Office no later than **three working days** prior to the last day of that month. Employee Benefits must physically receive the enrollment form for your benefits to be effective on the first of the month following your employment. If this documentation is not received three days prior to the last day of that month, your benefits will be effective on the next available effective date. (See Option Three)

Medical And Dental Premium Calculations

CORE premiums are required to be paid one month in advance. Accordingly, it is important you know that should you choose this option for a benefit effective date, the following scheduled premiums will be deducted from your first paycheck:

- First month of coverage prorated from your hire date to the end of the month; **plus**,
- The following month

If your first check is not enough to cover the required premiums, the remaining amount due will be deducted from your second paycheck.

Vision Premium

Vision premium will be deducted for the entire month if you are hired on or before the 14th of the month. If your hire date is after the 14th of the month your coverage is effective on the first of the month following your employment, however, there is no premium collected.

Submitting Required Paperwork

If your hire date is within the first three weeks of the month, then a representative from Personnel will collect and submit all of your benefit paperwork to Employee Benefits on first day of work.

If your hire date is the last week of the month you can either drop off your benefit enrollment form and Mesa Choice Flex Plan form accompanied by any required supporting documentation at the Employee Benefits Office located at 20 E. Main Street, Suite 600, Mesa, AZ 85201 **OR** mail them to:

Employee Benefits Administration
City of Mesa
P.O. Box 1466
Mesa, Arizona 85211-1466

If you mail the forms it is your responsibility to follow up to make sure that the documents arrived within the above -specified time frame. You can check the status by calling the Employee Benefits Office at 480-644-3329.

OPTION THREE

First Of The Month

Following One Month Of Continuous Employment

You may elect all your benefits (**CORE** and non-CORE) to be effective the first of the month following one month of employment. Since premiums are taken out one month in advance, your premiums are usually deducted beginning with your first paycheck. Typically, there is no need to catch up on premiums.

Hire Date	Benefit Effective Date		Hire Date	Benefit Effective Date
January 1 st	February 1		July 2 nd thru August 1 st	September 1
January 2 nd thru February 1 st	March 1		August 2 nd thru September 1 st	October 1
February 2 nd thru March 1 st	April 1		September 2 nd thru October 1 st	November 1
March 2 nd thru April 1 st	May 1		October 2 nd thru November 1 st	December 1
April 2 nd thru May 1 st	June 1		November 2 nd thru December 1 st	January 1
May 2 nd thru June 1 st	July 1		December 2 nd thru January 1 st	February 1
June 2 nd thru July 1 st	August 1			

This is the City's default option. If you choose either Option One or Two and neglect to meet the required time line for submitting your paperwork, then your benefit effective date will default to this option.

The enrollment form and required supporting documents will be collected by a representative from the Personnel Office and submitted to Employee Benefits on your first day of work.

DETERMINING BENEFIT PREMIUMS WORKSHEET

Benefit Effective Date Option	Anticipated Premiums Due From First Paycheck			
		Medical	Dental	Vision
<input type="checkbox"/> Option One Benefits become effective on your first day of employment with the City Hire Date _____	Premium from Hire date to end of Month (see proration table): Second Month of Coverage: If applicable, First half of Third Month: Premium Totals: Total Deductions From First Paycheck (Med/Dent/Vis):	\$ _____ \$ _____ \$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____ \$ _____ Date of First Paycheck: _____	\$ _____ \$ _____ \$ _____ \$ _____ _____
<input type="checkbox"/> Option Two Benefits become effective on the first day of the Month following your first day of employment with the City Hire Date _____	First Month of Coverage: If applicable, First half of Second Month: Premium Totals: Total Deductions From First Paycheck (Med/Dent/Vis):	\$ _____ \$ _____ \$ _____ \$ _____	\$ _____ \$ _____ \$ _____ Date of First Paycheck: _____	\$ _____ \$ _____ \$ _____ _____
<input type="checkbox"/> Option Three Benefits become effective the first of the month following 30 days of continuous employment Hire Date _____	First paycheck of the month before benefits become effective: _____ Total Deductions From First Paycheck (Med/Dent/Vis):	\$ _____ \$ _____	\$ _____ _____	\$ _____ _____

PAY PERIODS						
Beginning of Pay Period	Beginning of Pay Period	End of Pay Period		Beginning of Pay Period	Beginning of Pay Period	End of Pay Period
23-Nov-2009	06-Dec-2009	10-Dec-2009		15-Feb-2010	28-Feb-2010	04-Mar-2010
07-Dec-2009	20-Dec-2009	24-Dec-2009		01-Mar-2010	14-Mar-2010	18-Mar-2010
21-Dec-2009	03-Jan-2010	07-Jan-2010		15-Mar-2010	28-Mar-2010	01-Apr-2010
04-Jan-2010	17-Jan-2010	21-Jan-2010		29-Mar-2010	11-Apr-2010	15-Apr-2010
18-Jan-2010	31-Jan-2010	04-Feb-2010		12-Apr-2010	25-Apr-2010	29-Apr-2010
01-Feb-2010	14-Feb-2010	18-Feb-2010		26-Apr-2010	09-May-2010	13-May-2010

Annual Notification - Women's Health and Cancer Rights Act of 1998

Federal law requires the following notification: Group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. This Plan complies with the Women's Health and Cancer Rights Act (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending physician and the patient, including:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and physical complications for all stages of mastectomy, including lymphedemas.

Coverage is subject to the Plan's normal rules, including in-network co-payments or out-of-network annual deductibles and coinsurance provisions. If you have any questions about this law, including Plan benefits for mastectomies or reconstructive surgery, please contact Jody Topping, Employee Benefits Administrator at (480) 644-3009.

HIPAA – Health Insurance Portability and Accountability Act of 1996

Effective April 14, 2003, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that health plans like the City of Mesa Health Plan (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called Protected Health Information or PHI).

- The term "Protected Health Information" (PHI) includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- PHI does not include health information contained in employment records held by the City of Mesa in its role as an employer, including but not limited to health information related to disability, work-related illness/injury, sick leave, Family or Medical leave (FMLA), life insurance, dependent care FSA, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you or distributed to you upon enrollment in the Plan and is also available from the Employee Benefits Office or at www.mesachip.org.

Special Enrollment Event Notice:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage ends (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. Effective April 2, 2009, you and your dependents may also enroll in this Plan if you (or your eligible dependents):

- have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment in this Plan within 60 days after the Medicaid or CHIP coverage ends; or
- become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment in this Plan within 60 days after you (or your dependents) are determined to be eligible for such premium assistance.

To request Special Enrollment contact Employee Benefits at (480) 644-2299.

Medicare Mandatory Reporting Requirement:

As a health plan payor, the City of Mesa is required to comply with a number of federal laws, including HIPAA (see above) and the new Medicare Mandatory Reporting Requirement. This new requirement came about because of increased misunderstandings by Medicare recipients regarding the primary/secondary relationship between Medicare and their other Group Health Plan (like those offered by the City of Mesa).

When a person becomes eligible for Medicare, either because they have reached their Medicare-eligibility age OR they have been disabled for at least 2 years, they are automatically enrolled in Medicare Part A, which covers the person under Medicare for Hospitalizations. They will also have the option of enrolling in Medicare Part B (for professional services, such as doctor visits, lab and xray services), of which there is a monthly premium. When a person is also covered by another insurance plan, such as those offered by the City of Mesa, both the City and Medicare must determine which plan is primary (i.e. which plan pays first when services are rendered) and which plan is secondary.

Many people assume that when they become eligible for Medicare that Medicare is automatically primary. This is not necessarily the case, especially if the person is still an active employee or is the spouse of an active employee. For this reason, the Centers for Medicare and Medicaid Services (CMS) has enacted the new Medicare Mandatory Reporting Requirement—to ensure those who are enrolled in Medicare and another group health plan understand which plan is considered their primary insurance.

To facilitate this process, CMS is requiring all health insurance payors to submit the names and social security numbers of all of their members, regardless of their age or Medicare status. They will then verify which people are enrolled in Medicare and will communicate this information to the Employee Benefits Office, so we can notify the member which insurance coverage should be considered primary. As a result of this requirement, we are asking all plan members (employees and retirees) to provide us with the social security numbers of their dependents (spouses and children). We will then communicate this information to CMS as required by federal law.

Please note this information will be kept completely confidential and private, as the City of Mesa Employee Benefits Office is bound by HIPAA to maintain all information private. If you have any questions or concerns about this new requirement, please contact Jody Topping, Employee Benefits Administrator at (480) 644-3009.

Medicare Notice of Creditable Coverage

Important Notice from the City of Mesa about Prescription Drug Coverage for People with Medicare

**This notice is for people with Medicare.
Please read this notice carefully and keep it where you can find it.**

This Notice has information about your current prescription drug coverage with the City of Mesa and the prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare's prescription drug coverage and can help you decide whether or not you want to enroll in that Medicare prescription drug coverage. At the end of this notice is information on where you can get help to make a decision about Medicare's prescription drug coverage.

- **If you and/or your family members are not now eligible for Medicare, and will not be eligible during the next 12 months, you may disregard this Notice.**
- **If, however, you and/or your family members are now eligible for Medicare or may become eligible for Medicare in the next 12 months, you should read this Notice very carefully.**

This announcement is required by law whether the group health plan's coverage is primary or secondary to Medicare. Because it is not possible for our Plan to always know when a Plan participant or their eligible spouse or children have Medicare coverage or will soon become eligible for Medicare we have decided to provide this Notice to all plan participants.

Prescription drug coverage for Medicare-eligible people is available through Medicare prescription drug plans (PDPs) and Medicare Advantage Plans (like an HMO or PPO) that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more drug coverage for a higher monthly premium.

The City of Mesa has determined that the prescription drug coverage under the following prescription drug plan options (the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan and the Copay Choice Plan) are "creditable".

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

Because the plan option(s) noted above are, on average, at least as good as the standard Medicare prescription drug coverage, **you can elect or keep prescription drug coverage under the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan and you will not pay extra if you later decide to enroll in Medicare prescription drug coverage.** You may enroll in Medicare prescription drug coverage at a later time, and because you maintain creditable coverage, you will not have to pay a higher premium (a late enrollment fee penalty).

REMEMBER TO KEEP THIS NOTICE

If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

WHEN CAN YOU JOIN A MEDICARE DRUG PLAN?

Medicare-eligible people can enroll in a Medicare prescription drug plan at one of the following 3 times:

- when they first become eligible for Medicare; or
- during Medicare's annual election period (from November 15th through December 31st); or
- for beneficiaries leaving employer/union coverage, you may be eligible for a Special Enrollment Period (SEP) in which to sign up for a Medicare prescription drug plan.

When you make your decision whether to enroll in a Medicare prescription drug plan, you should also compare your current prescription drug coverage, (including which drugs are covered and at what cost) with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

YOUR RIGHT TO RECEIVE A NOTICE

You will receive this notice at least every 12 months and at other times in the future such as if the creditable/non-creditable status of the prescription drug coverage through this plan changes. You may also request a copy of a Notice at any time.

WHY CREDITABLE COVERAGE IS IMPORTANT (When you will pay a higher premium (penalty) to join a Medicare drug plan)

If you do not have creditable prescription drug coverage when you are first eligible to enroll in a Medicare prescription drug plan and you elect or continue prescription drug coverage under a **non-creditable** prescription drug plan, then at a later date when you decide to elect Medicare prescription drug coverage you may pay a higher premium (a penalty) for that Medicare prescription drug coverage for as long as you have that Medicare coverage.

Maintaining creditable prescription drug coverage will help you avoid Medicare's late enrollment penalty. This **late enrollment penalty** is described below:

If you go 63 continuous days or longer without creditable prescription drug coverage (meaning drug coverage that is at least as good as Medicare's prescription drug coverage), your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have either Medicare prescription drug coverage or coverage under a creditable prescription drug plan. You may have to pay this higher premium (the penalty) as long as you have Medicare prescription drug coverage.

For example, if 19 months pass where you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than the Medicare base beneficiary premium. Additionally, if you go 63 days or longer without prescription drug coverage you may also have to wait until the next November to enroll for Medicare prescription drug coverage.

WHAT ARE MY CHOICES?

You can choose any **one** of the following options:

Your Choices:	What you can do:	What this option means to you:
Option 1	You can select or keep your current medical and prescription drug coverage with the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan and you do not have to enroll in a Medicare prescription drug plan.	<p>You will continue to be able to use your prescription drug benefits through the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan.</p> <ul style="list-style-type: none"> You may, in the future, enroll in a Medicare prescription drug plan during Medicare's annual enrollment period (during November 15-December 31 of each year). As long as you are enrolled in creditable drug coverage you will not have to pay a higher premium (a late enrollment fee) to Medicare when you do choose, at a later date, to sign up for a Medicare prescription drug plan.
Option 2	<p>You can select or keep your current medical and prescription drug coverage with the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan and also enroll in a Medicare prescription drug plan.</p> <p>If you enroll in a Medicare prescription drug plan you will need to pay the Medicare Part D premium out of your own pocket.</p>	<p>Having dual prescription drug coverage under this Plan and Medicare means that this Plan will coordinate its drug payments with Medicare, as follows:</p> <ul style="list-style-type: none"> for Medicare eligible Retirees and their Medicare eligible Dependents, Medicare Part D coverage pays primary and this group health plan pays secondary. for Medicare eligible Active Employees and their Medicare eligible Dependents, this group health plan pays primary and Medicare Part D coverage pays secondary. <p>Note that you may not drop just the prescription drug coverage under the Choice PPO Plan, Choice Plus PPO Plan, Basic Choice Plan or the Copay Choice Plan. That is because prescription drug coverage is part of the entire medical plan. Generally, you may only drop medical plan coverage at this Plan's next Open Enrollment period.</p> <p>Note that each Medicare prescription drug plan (PDP) may differ. Compare coverage, such as:</p> <ul style="list-style-type: none"> PDPs may have different premium amounts PDPs cover different brand name drugs at different costs to you; PDPs may have different prescription drug deductibles and different drug copayments; PDPs may have different networks for retail pharmacies and mail order services.

FOR MORE INFORMATION ABOUT YOUR OPTIONS UNDER MEDICARE'S PRESCRIPTION DRUG COVERAGE

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare & You" handbook. A person enrolled in Medicare (a "beneficiary") will get a copy of this handbook in the mail each year from Medicare. A Medicare beneficiary may also be contacted directly by Medicare-approved prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number), for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Para mas información sobre sus opciones bajo la cobertura de Medicare para recetas medicas.

Revise el manual "Medicare Y Used" para información detallada sobre los planes de Medicare que ofrecen cobertura para recetas medicas. Visite www.medicare.gov por el Internet o llame GRATIS al 1 800 MEDICARE (1-800-633-4227). Los usuarios con teléfono de texto (TTY) deben de llamar al 1-877-486-2048. Para mas información sobre la ayuda adicional, visite la SSA en línea en www.socialsecurity.gov por Internet, o llámeles al 1-800-772-1213 (Los usuarios con teléfono de texto (TTY) deberán llamar al 1-800-325-0778).

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

For more information about this notice or your current prescription drug coverage contact:

Contact: City of Mesa, Employee Benefits Administrator
Address: 20 E. Main St., Ste 600, Mesa, AZ 85201
Phone Number: (480) 644-3009

As in all cases, the City of Mesa reserves the right to modify benefits at any time, in accordance with applicable law. This document (dated **October, 2009**) is intended to serve as your Medicare Notice of Creditable Coverage, as required by law.

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IMPORTANT PHONE NUMBERS

Employee Benefits	(480) 644-2299	Benefit Information & Inquiries
American Health Group	(602) 265-3800 or	Precertification
	(800) 847-7605	
EAP Preferred	(602) 264-4600	Employee Assistance Program
Medco	(800) 711-0917	Prescription Drug Program
Vision Service Plan	(800) 877-7195	Vision Benefits
CIGNA Life Insurance*	(800) 732-1603	Supplemental Life*
Standard Life Insurance	(800) 368-2659	Short Term Disability Benefits
HealthSmart PPO	(800) 687-0500	Out-of-State Network Customer Service
		(for members outside of Arizona only)

*For Questions Regarding Underwriting originally sent to CIGNA. Please Call Employee Benefits for any other questions regarding Supplemental Life



HELPFUL WEBSITES

www.azblue.com

To find a current in-network provider in Arizona.

www.medco.com

To find information about your prescription drug benefit, locate a pharmacy, and order prescriptions from the home delivery pharmacy.

www.mesachip.org

To view the City of Mesa Plan Document, get benefit forms, and your benefit information and claim history.

www.eappreferred.com

To get information on EAP counseling and referrals to mental health providers.

www.healthsmart.net

To find providers in out-of-state directory or for customer service (for insureds living outside of Arizona only).

www.vsp.com

To find a Vision Service Plan provider and other coverage information

<http://insidemesa/benefits/default.asp>

City Intranet. To view the Employee Benefits Home Page on InsideMesa. The City of Mesa Plan Document is also available on this site.